

Report to Congress
**“Study Regarding Barriers to Participation of
Farmworkers in Health Programs”**

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INTRODUCTION

RESPONSE TO CONGRESS

Section 404 of the Health Care Safety Net Amendments of 2002 (P.L. 107-251) required the Secretary of Health and Human Services to conduct a study on the problems experienced by farmworkers and their families under Medicaid and SCHIP, including the barriers migrant and seasonal farmworkers¹ face in accessing health services through Medicaid and SCHIP, and the lack of portability of Medicaid and SCHIP coverage for farmworkers who are determined eligible in one state but who, due to the seasonal nature of their work, periodically move to other states. Section 404 of P.L. 107-251 is attached at Tab A.

The legislation also specified that the report examine possible solutions to the problems identified in order to increase enrollment and access to benefits for farmworkers, including:

- Interstate compacts;
- Demonstration projects;
- Use of current law flexibility;
- National migrant family coverage;
- Public-private partnerships; and
- Other possible solutions.

Finally, the legislation required that the Secretary consult with the following in conducting the study:

- Farmworkers;
- Individuals with expertise in providing health care, including designees of national and local organizations representing community and migrant health centers and other providers;
- Individuals with expertise in health care financing;
- Foundation representatives and non-profit entities that have conducted or supported research on farmworker health care financial issues;
- Representatives of the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA);
- Representatives of State governments;
- Representatives from the farm and agricultural industries; and
- Designees of labor organizations representing farmworkers.

¹ The legislation defines a “farmworker” as a migratory agricultural worker or seasonal agricultural worker as defined in section 330(g)(3) of the Public Health Service Act (42 U.S.C. 254b(g)(3)), and includes a family member of such a worker.

PROCESS AND METHODOLOGY

In response to the Congressional mandate, the Department of Health and Human Services (DHHS) delegated responsibility for conducting the study to the CMS, Office of Research, Development, and Information (ORDI).

CMS staff convened an intra-departmental HHS workgroup to discuss and develop a work plan for the study. Staff from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), HRSA, and the CMS' Center for Medicaid and State Operations (CMSO) participated. The workgroup members met with representatives from the National Advisory Council on Migrant Health to discuss Departmental efforts underway in conducting the study and to hear the views and concerns of committee members.

The workgroup convened an expert advisory panel, as identified in the statute, to discuss possible solutions to the challenges of Medicaid and SCHIP access and portability. This expert advisory panel meeting, held on December 2, 2003, at the Humphrey Building in Washington, DC, was structured to both obtain input from the expert consultants and to encourage a facilitated discussion among the consultants and selected observers.

A list of panel participants and their organizations are attached at Tab B. State Medicaid, SCHIP and health department representatives from California, Florida, Michigan, Texas and Washington participated. Other participants included representatives from: the largest private fruit and vegetable grower from Florida, major growers' associations from California and Washington, a California-based labor organization serving farmworkers, a national association of agricultural employers, several community and migrant health centers, public hospitals, Medicaid managed care plans, medical school residency and training programs, and an organization that trains 'promotoras de salud' community health workers. Health information and technology specialists, health care financing experts and researchers with a special interest in farmworker and family health issues also participated.

A diverse group of Federal representatives from the DHHS, the Department of Agriculture's Food and Nutrition Service, the Department of Labor, the Office of Civil Rights, and the Executive Office of Management and Budget attended the meeting, largely in the role of observers. Health Services Research, Inc., of Washington, DC facilitated the meeting under an existing contract with ASPE.

Workgroup staff also obtained direct input from farmworkers and their families through visits to a migrant labor camp and community and migrant health center in New York State. Furthermore, direct testimony by farmworkers and family members was provided to workgroup staff at the HRSA-sponsored Eastern Migrant Stream Conference in Tarrytown, NY in October 2003.

BACKGROUND ON MIGRANT AND SEASONAL FARMWORKERS

Enrollment in Medicaid and SCHIP

To be eligible for Medicaid, an individual or family must fit into an eligibility category or group. Generally, the eligibility categories are limited to low-income families, pregnant women, children, and aged and disabled individuals, including those with a mental disorder. Non-disabled, childless adults, non-disabled adults living apart from their children, or non-aged adults are not categorically eligible for Medicaid. In addition, most qualified aliens who entered the country on or after August 22, 1996, are subject to a 5-year bar on Medicaid eligibility, except for specified emergency services. Generally, SCHIP eligibility is limited to children. Moreover, to prevent fraud, Medicaid generally requires applicants to provide a Social Security number (SSN) and, documentary evidence of identity and citizenship or satisfactory immigrant status. Those who enter the United States, including migrant farmworkers, might find it difficult to obtain a SSN or to provide the required documentation. In addition, since many migrant farmworkers are single adults (particularly single males) or parents who live apart from their children, or are qualified aliens subject to the 5-year bar on eligibility, they are not categorically eligible for Medicaid or SCHIP.

As requested by Congress, the report examines the barriers to enrollment experienced by farmworkers and their families under Medicaid and SCHIP. There are three categories of potential barriers to enrollment: linguistic and cultural barriers; a lack of outreach and outstationed eligibility assistance; and a lack of application and eligibility determination assistance.

Nature of Migrant and Seasonal Workforce

Migrant farmworkers and seasonal farm laborers provide labor for the compensation they receive from farmers and growers in the United States at farms that are planted, tended, and picked seasonally and/or annually. The U.S. Department of Labor estimates that in 1999-2000 there were approximately 2.5 million U.S. agricultural workers.¹ A little over a quarter (28 percent) of these workers were engaged in beef, poultry, fish, and other livestock production, and the rest were engaged in crop production, including horticultural products, cash grains, fruits, nuts, and vegetables.² In Federal fiscal year 1999-2000, 50 percent of those who engaged in crop production were migrants, and 55 percent were not authorized to work.

The agricultural economy is of critical importance to the U.S. economy. In 2002, \$26 billion in cash farm receipts were reported annually in California alone.³

Many farmworkers and their families are from Haiti, Jamaica, Asia, Central American nations and the Republic of Mexico. Although 58 percent of them maintain their homes in this country, only about 19 percent of all farmworkers in the United States are U.S.-born.⁴ Among the foreign born, 97 percent were born in Mexico.⁵

Farmworker employment is unique in that it can be short in duration and workers often need to travel to stay employed. Many farmworkers and their families migrate across states, often across

recognized “migrant streams” along the Eastern Seaboard, through the Mid-Continent, and up and down the West coast, changing residency frequently as they move throughout the United States to perform their work.

Nearly a third of foreign-born workers are newcomers who have arrived in the U.S. within the last 2 years, and most (70 percent) of these lacked authorization to work. Considering that the average stay in agriculture for a worker is between 5 and 6 years, as older, experienced workers continue to leave agriculture, the quantity of undocumented workers is expected to increase.⁶

Predominantly Male Workforce

In addition to being largely foreign-born and undocumented, farmworkers are predominantly male. Only 20 percent of the farmworker workforce was female in 2001.⁷ The predominance of a male farm labor force is characterized by increased health risks but decreased utilization of health care services. In some cases, migrant labor camps are composed primarily of single males.

This male workforce has lower levels of health care service utilization than the general population. A statewide study of California farmworkers found that more than a third of women reported a medical visit within the previous 5 months and nearly 75 percent had a medical visit at some point in the prior 2 years, while nearly a third of the men said they had never been to a doctor or clinic in their entire lives and just under half reported a doctor or clinic visit in the prior 2 years.⁸

Illness and Participation in Insurance Arrangements

Similar to many other individuals living at or below the Federal Poverty Level (FPL), migrant farmworkers and their families are at increased risk for illness and disease. A study has shown that they suffer from higher serum cholesterol, high blood pressure, and obesity more than the general population.⁹

Despite the low annual incomes of farmworkers, few use contribution-based services or needs-based services. For example, only a fifth used unemployment insurance, and only 1 percent used disability insurance or Social Security. The National Agricultural Workers Survey (NAWS) 2001-2002 indicates that 5 percent of farmworkers have publicly-funded health insurance.¹⁰ Seventeen percent of all farmworkers and their families used needs-based services of any kind such as temporary assistance to needy families, WIC, Medicaid, and public housing.¹¹

In a survey of health service use by children of migrant farmworkers in North Carolina, 44 percent of children had visited a doctor in the preceding 3 months; of these, 11 percent had coverage by some form of insurance. Of the whole sample, 20 percent had Medicaid and 4 percent had SCHIP.¹² This survey found that “migrant children using health services are distinct from nonusers with regards to socio-demographic factors, enabling resources, and need for care.” Users were more likely to be younger children and had lived in the area for 6 or more months.¹³

Results from the 2001-2002 NAWS indicate significant differences in insurance coverage across three groups of migrant farmworkers and their families defined as “settled,” “migrant,” and “newcomers.” The more settled the worker, the more likely that the worker and family lived in the area and that family members had publicly-funded health insurance. This finding was consistent across the Eastern Seaboard, Mid-Continent and West Coast migrant streams.¹⁴

CURRENT PROGRAMS AVAILABLE TO FARMWORKERS

Approximately 650,000 migrant farmworkers and their families receive health care services through community health center programs under section 330 of the Public Health Service Act, including specifically targeted services for migrant health programs under section 330(g) of the Act. Services are offered on a sliding fee scale, and they are available on evening and weekend hours. Centers are staffed with bilingual and culturally competent providers. They often provide transportation to the center or provide mobile health services. Health centers engage in direct and supportive service delivery solutions as well as outreach activities, including assisting in applications for programs that farmworkers may be eligible for, including Medicaid and SCHIP. Also, physicians in the National Health Service Corps serve migrant populations through their community and migrant health center medical practices

Community and migrant health centers provide an important basic source of care for many migrant farmworkers and their families. Health centers continue to expand under President Bush’s initiative to increase the number of patients served by health centers in order to provide access to quality and culturally appropriate direct health care and supportive services to low-income and uninsured individuals. The President’s Health Centers Initiative site increase and expansion has, and will continue to reach and deliver primary and preventive care services to migrant individuals and families through the community and migrant health centers. Under Section 330(r)(2)(B) of the Public Health Service Act, 81.5 percent of the health center budget line is statutorily allocated to community health centers, and 8.6 percent is allocated to migrant health centers resulting in a combined substantial investment in services to migrant populations realized through both the community and migrant health center allocations.

The existing network of community and migrant health centers provides care to migrant and seasonal farmworkers and their families throughout the Nation. The network of community and migrant health center organizations and providers, continue to provide a special focus on the health care for this population, but the centers are not able to provide care for all farmworkers and their families.

Migrant farmworkers also use a variety of other primary care and acute care resources across the country, some of which are available to them under the auspices of Medicaid and SCHIP. In addition, farmworkers and their families draw upon the assistance of approximately 10 programs that are specific to migrant and seasonal farmworkers (which are not specifically related to health care) and numerous other general programs such as food stamps. Farmworkers and their families also may qualify for other services provided by state and local government, or funded through private initiatives, each governed by its own particular definition or eligibility standard. As with these state and local programs, each Federal program has its own definition of migrants and/or seasonal farmworker, intake procedures, and eligibility standards. This makes it difficult

for farmworkers and their families to learn about, apply for, and gain access to programs for which they may be eligible.

LANGUAGE AND CULTURE

According to the Department of Labor's National Agriculture Worker's Survey, the primary language of migrant farmworkers is Spanish, with only 12 percent speaking English. An increasing number of migrants from Southern Mexico and Central America speak one of several indigenous languages. In addition, due to limited formal educations, most farmworkers would have difficulty obtaining information from printed materials in any language.

The U.S. DHHS and State Medicaid and SCHIP agencies have taken steps to address linguistic issues. On August 8, 2003, DHHS released guidance to recipients of Federal financial assistance, including Medicaid and SCHIP programs, regarding the provision of language assistance services to limited English proficient (LEP) individuals. In addition, DHHS has surveyed states on several occasions and has found that most states translate their Medicaid and SCHIP applications into Spanish and other languages frequently-used in those states.

OUTREACH AND OUTSTATIONED ELIGIBILITY ASSISTANCE

Over the past several years, states have made innovative program design choices in application, eligibility determination, and renewing eligibility in SCHIP and Medicaid. Many states have developed joint Medicaid and SCHIP applications and allow applicants to apply by phone and online. Renewing eligibility has also been simplified. Many states only require enrollees to renew eligibility every 12 months and have simplified renewal applications by asking enrollees to update their information to reflect any changes as opposed to re-applying to the program. Pursuant to enactment of section 6036 of the Deficit Reduction Act of 2005 (DRA – P.L. 109-171), as amended by section 405 of P.L. 109-383, the "Tax Relief and Health Care Act of 2006," Medicaid recipients who claim to be citizens will generally be required to document their citizenship and identify at the first redetermination of eligibility occurring after July 1, 2006, if they had not done so when first applying for Medicaid, unless exempted by the regulations at 42 CFR 435.1008 or 436.1004. Many states have also adopted presumptive eligibility, which allows them to enroll children at the point of service if a child appears to be eligible for SCHIP or Medicaid, resulting in children receiving care more quickly.

Despite the efforts by the Federal and state governments described above, due in part to a high turnover rate in their workforce, but also because of migration, poverty, illiteracy, and other factors, many farmworkers are not informed of programs designed to assist them. Farmworkers and their families often are not aware of services available in the various locations where they work.¹⁵ This lack of awareness keeps many hired farmworkers from reporting incidents or seeking aid for health problems.¹⁶

Farmworkers and their families often work in remote locations where there is little or no public transportation. If they seek to enroll in Medicaid or SCHIP or determine if they are eligible, they face difficulties in getting to an office to complete an application due to a lack of transportation, or due to office hours that are limited to typical business hours in which a farmworker would be

in the field. They might also not have access to technological devices such as telephones, fax machines, or computers, which would enable them to file or complete an application without having to travel to an office. And, as discussed above, if they can get to a Medicaid or SCHIP office or get an application, they might find it difficult to complete the application process due to illiteracy or a lack of applications in their primary languages which are increasingly indigenous native American languages. However, most states where migrant farmworkers live do have applications available in Spanish.

Estimates from the Department of Labor's National Agricultural Workers Survey indicate that migrant and rural outreach services reach 20 percent of the full population of hired farmworkers. Among the areas of concern are the lack of occupational medicine training among clinicians and language and cultural differences between farmworkers and clinicians that makes communication with each other difficult.¹⁷ Additionally, if eligible and enrolled, availability of and access to health care facilities also contributes to the low use of services, particularly because many facilities often are not open in the evening hours, and farmworkers are unwilling to lose wages to visit the center during the day.

The existing network of community and migrant health centers provides care to migrant and seasonal farmworkers and their families throughout the nation. However, these facilities have limited capacity, resources, and locations to serve the farmworkers and their families. The network of community and migrant health center organizations and providers supplement the existing health infrastructure across the nation to provide a special focus on the health care for this population, but the centers are not expected to serve all farmworkers and their families eligible for Medicaid or SCHIP nor are they capable of meeting all the health care needs of those using these services.

ELIGIBILITY DETERMINATIONS AND APPLICATIONS

Because the migrant farmworker population consists primarily of men, the vast majority of migrant farmworkers are not eligible for SCHIP or Medicaid; however, their dependents may be. Children who are born in the United States of America are American citizens, regardless of the immigration status of their parents. As citizens, they are eligible for Medicaid and SCHIP programs in the same manner as any other citizen of a state. Multi-citizenship families face unique challenges in accessing and obtaining health care services.

Citizenship and Immigration Status

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted the Medicaid eligibility of legal immigrants so that those entering in the country could generally not receive coverage during the first 5 years in residence, except in the event of an emergency. As a result, only U.S. citizens (who comply with the citizenship/nationality verification requirements of the DRA), as amended by the provisions of P.L. 109-383, the "Tax Relief and Health Care Act of 2006," nationals and qualified aliens who are in a Medicaid eligibility category and who are not subject to the 5-year bar are eligible for regular Medicaid and SCHIP coverage. Non-qualified aliens, a group that includes undocumented immigrants, are only eligible for emergency medical services under Medicaid, and only if they are otherwise

eligible for Medicaid. They are not eligible for separate SCHIP programs. SCHIP Medicaid expansion programs may have different requirements from separate SCHIP programs, however “SCHIP” in this report refers to separate SCHIP programs. Therefore, migrant farmworkers and their families who are undocumented immigrants are not generally eligible for Medicaid or SCHIP coverage.

In addition to these legal guidelines, migrant farmworkers who are nationals or qualified aliens might be reluctant to apply for Medicaid or SCHIP for fear that their receipt of public benefits might affect their immigration status. Also, these farmworkers who have family members who are non-qualified aliens might avoid applying for Medicaid or SCHIP for fear that they will place those family members in legal jeopardy.

Income Determinations

Since income fluctuates with the seasonal nature of their work, migrant farmworkers and their families may not meet the income eligibility requirements for Medicaid or SCHIP. In some instances, a family’s earnings in the couple of months they worked are extrapolated to determine an average annual income for assessing their eligibility. This determination would result in an inflated estimate of a family’s average monthly income which means migrant farmworkers’ families may not be eligible for Medicaid or SCHIP services even in the months in which they are not working since their average monthly income is higher than their actual income for that month.

These eligibility determinations are complicated even further as farmworkers move among states to increase their earnings and face different eligibility standards and methodologies in different states. The inability of farmworkers and their families to continue accessing and receiving health services as they move among states is discussed below.

PORTABILITY

As previously noted, Medicaid is designed to provide health care benefits primarily to certain categories of low-income families, pregnant women, children, and aged, blind, and disabled individuals. In addition, SCHIP programs are available to children in families with incomes higher than Medicaid thresholds. Both of these programs operate under Federal statute and regulations that define complex parameters of eligibility, coverage, and payment. States are authorized to administer and implement these programs within Federal parameters.

Because states have flexibility to establish eligibility groups and income and resource standards for Medicaid and SCHIP, migrant farmworkers and their families may be eligible for the program in one state, but not another, even if their income and resources and family composition remain constant.

States pay out-of-state Medicaid/SCHIP claims in certain situations; however, they are generally not organized or able to facilitate portable health insurance coverage. Program variations make administrative coordination and efficient operation across programs difficult.

Verification and Enrollment

Farmworkers often need to move to another state for work before the eligibility determination process is complete and assistance is made available in the state in which they are living. The use of different processes and forms in different states, as well as differing eligibility periods and criteria, are a potential barrier for farmworkers to enroll in Medicaid and SCHIP and maintain their eligibility as they move to work from state-to-state.

In addition, states must require that Medicaid applicants provide their SSN (Separate SCHIP programs can impose this requirement as well), and that Medicaid and SCHIP applicants provide proof of their immigration status. As a result of the enactment of the DRA, individuals claiming to be citizens or nationals who seek to establish Medicaid eligibility must provide satisfactory documentary evidence of citizenship or nationality. The types and forms of acceptable documentation are specified at 42 CFR 435.407 and 436.407. State Medicaid and SCHIP programs can also impose other documentation requirements on applicants and recipients. These documentation requirements can be a potential barrier to enrollment if farmworkers do not have them in their possession when making an application or undergoing the renewal process.

Applications and Eligibility Determination Time Period

The eligibility determination time period is often longer than the amount of time a farmworker is in a state working due to the migrant nature of the work. For non-disabled applicants, regulations at 42 CFR 435.911 specify that states have a maximum of 45 days to complete the eligibility process. If recipients apply for Medicaid in their work state, they might have difficulty accessing its benefits, as the processing time may not be short enough in that state to complete the eligibility process and to eventually receive medical services once the process is complete.

Residency Status Determinations

Federal regulations (42 CFR 435.403) define “residence” for state Medicaid eligibility purposes as either the state in which a person lives with intent to remain there permanently, or the state in which a person is working. Therefore, migrant farmworkers and their families can apply for Medicaid in either the state in which they make their permanent residence or in the state in which they are working at that time. When making eligibility determinations, state caseworkers determine whether or not applicants are living in that state with the intent to remain or are working in the state.

A farmworker could be enrolled in one state and, after moving, seek enrollment in another state. States are not required to have special provisions for immediate disenrollment; in fact, some states might not make disenrollment effective until the end of the month. A farmworker could experience a lag in coverage if he/she waits to be disenrolled in the previous state before applying for coverage in the new state.

Payment for Out-of-State Services

Providers in other states might not be willing to accept out-of-state Medicaid cards since the “home state” is only obligated to pay for services in medical emergencies when the needed medical services are more readily available in the other state, or when it is a general practice for recipients to receive services in another state. Providers in other states might not be willing to accept out-of-state cards due to complicated reimbursement mechanisms and delayed payments. Providers who do accept out-of-state cards then encounter difficulties in getting agreement from the issuing state to pay the bill.

POSSIBLE SOLUTIONS

Possible solutions for increasing enrollment and access to benefits for farmworkers who are eligible for Medicaid and SCHIP are discussed below. The potential solutions discussed would not be available to the large number of farmworkers that are not eligible for Medicaid or SCHIP, except in the case of particular states that provide Medicaid to non-disabled, single adult males through a Medicaid section 1115 demonstration¹⁸ that expands coverage to single adults. Therefore, a limited number of farmworkers would be helped by these solutions. The request from Congress asked that the study consider six possible areas for solutions: interstate compacts; demonstration projects; use of current law flexibility; national migrant family coverage; public-private partnerships and other possible solutions.

INTERSTATE COMPACTS

Under current Federal law and regulations, states may enter interstate agreements to facilitate administration of their Medicaid and SCHIP programs. Increasing the number of interstate compacts can address the previously discussed potential portability issues that farmworkers and their families face in seeking Medicaid or SCHIP assistance.

Interstate compacts are agreements between states that provide the framework for formalized interstate cooperation. They range from a more basic model in which states recognize each other’s eligibility determinations to models with states fully reimbursing out-of-state providers. States may seek to develop interstate agreements or compacts to facilitate timely eligibility determinations or redeterminations for applicants and recipients, such as migrant farmworkers, and agree upon detailed mechanisms by which payment reciprocity can be made among two or more states. These arrangements do not necessarily require Federal authorization.

The primary example of an interstate compact model in Medicaid that has been effectively employed is the Interstate Compact on Adoption and Medical Assistance (ICAMA). This agreement, established in 1986, provides more seamless Medicaid coverage to interstate adoption cases for the 46 member states. ICAMA is a compact that has been adopted by the legislatures of compact member states or by an executive branch official who acts for the state and signs the compact.

The compact governs the interstate delivery of and payment for medical services and adoption assistance payments and subsidies for adopted children with special needs. ICAMA originated as a method to protect special needs children when a family in another state adopts them from one state, or when the adoptive family moves from one state to another. The compact ensures that these children continue to receive appropriate medical assistance and subsidies by establishing a coordinated method for payment of benefits. Benefits coordinated under ICAMA include Medicaid, Title IV-E and Title XX payments, state subsidies, and others. When a family moves or a child is relocated to another state, the child has a Medicaid card from the “sending” state; however, medical providers in states outside the compact are often reluctant to accept Medicaid from another state. To ensure these children receive services, if a child relocates to an ICAMA member state, the state to which the child has relocated will provide a Medicaid card. This ensures that a “receiving” state is not encumbered with expenses for assistance negotiated in the “sending” state. It also ensures that children continue to receive assistance and benefits without the necessity of asking the “sending” state for reimbursement.

By establishing and joining an interstate compact on medical assistance to migrant farmworkers and their families, states can more readily recognize each other’s eligibility determinations and reimburse out-of-state providers; as a result, they can provide more seamless Medicaid coverage to migrant farmworkers and their families. CMS is available to work with states who wish to implement an interstate compact to enhance portability of Medicaid coverage for eligible migrant farmworkers and their families.

Models of possible interstate compacts may include:

Faster Verification and Enrollment when Moving from State to State for Work:

After eligible individuals become enrolled in Medicaid or SCHIP in a state under that state’s policies and process, other states would allow rapid enrollment by accepting the initial state’s determination of basic eligibility criteria.

CMS would advise those states interested in interstate compacts on known best practices for rapid disenrollment and re-enrollment of eligible individuals as farmworkers and their families move between states. Electronic disenrollment in prior states as soon as the new ‘work state’ determines eligibility would facilitate this and so would limiting eligibility verification requirements to proof of citizenship.

Out of Area Coverage Across States After “Home State” Enrollment:

After eligible individuals become enrolled in Medicaid and SCHIP in a “home state,” they would carry that coverage with them as they travel to other states for work.

Wisconsin is a State that provides a good example of the use of an interstate compact to recognize other States’ Medicaid/SCHIP coverage. Since 1998, Wisconsin has issued a Medicaid/SCHIP card to any farmworker with a Medicaid/SCHIP card from another state. It is a unilateral program, however, because other states do not participate in recognizing farmworkers with Wisconsin’s Medicaid/SCHIP coverage. Wisconsin

covers the costs of the Medicaid/SCHIP coverage for the farmworkers traveling into the state. It appears, however, that Wisconsin did not experience any noticeable, dramatic increase in costs after it instituted this policy because the reported number of migrant farmworkers who are eligible for Medicaid/SCHIP and traveling across state lines is small.

DEMONSTRATION PROJECTS

Section 1115 (a) of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. States can request section 1115 authority to create a standard set of benefits across states that differs from the set of benefits provided under the state plan in each of those states or to expand coverage to groups of individuals, including parents and caretaker relatives, or to provide greater flexibility in their programs. Budget neutrality is required for programs approved under section 1115 authority under the policies of the Office of Management and Budget. In the case of section 1115 demonstrations, including HIFA demonstrations, proposals must demonstrate allotment neutrality.

States may wish to use current law demonstration authority to test innovative methods of increasing the ability of eligible farmworkers and their families to enroll in the Medicaid and SCHIP programs. These innovative methods may include interstate compacts and Medicaid and SCHIP vouchers to assist individuals in purchasing health insurance coverage. There are a number of ways to use section 1115 demonstration authority to structure an interstate compact, including simultaneous enrollment in multiple states using a multi-state card, creating reciprocity arrangements between states for determining eligibility and multiple states creating interstate standard benefit packages. CMS can provide technical assistance to States considering or planning to submit a section 1115 application.

USE OF CURRENT LAW FLEXIBILITY

As noted in the section on enrollment, outreach and assistance with applications procedures is a key component of ensuring eligible farmworkers and their families are aware of their ability to enroll in Medicaid or SCHIP.

Through existing State Plan authority, states may conduct a wide range of activities for eligible and participating Medicaid recipients. Some of these may be designed to improve service delivery coordination; enhance enrollment and portability arrangements; and improve coordination between HRSA-sponsored community and migrant health centers and state Medicaid and SCHIP programs. States may use State Plan authority to enhance Medicaid and SCHIP managed care coordination at state and health plan levels to facilitate Medicaid enrollment and portability. Examples are available in the private sector that show how system communication within and across Medicaid and SCHIP programs could be adapted to take advantage of available information technology and web-based applications. These may be applied as part of a strategy to improve the portability of health care for migrant farmworkers by using electronic health summaries under current law flexibility.

Another option for states under SCHIP is the unborn child state plan amendment option. CMS allows States to cover pregnancy-related services and care for unborn children through SCHIP and, as of June 2006, nine States (Arkansas, California, Illinois, Massachusetts, Michigan, Minnesota, Rhode Island, Texas, and Washington) have adopted this option. This option could make a significant difference in the health of infants in states with large numbers of pregnant migrant workers.

More work is needed to assure that migrant farmworker families, especially women and children, are made aware of their potential Medicaid/SCHIP program eligibility through improved coordination of existing program resources, especially at locations where these families will have contact as they change employment and residency status. Through the coordinated work by local, county, state, and Federal agencies, together with foundations, providers, advocacy organizations and employers, better outreach and access could be achieved by eligible farm workers and their families.

States could coordinate outreach and enrollment activities for eligible farmworkers and their families with community and migrant health centers funded under section 330 of the Public Health Service Act and through the use of outstationed eligibility workers at such centers under section 1902(a)(55) of the Social Security Act. States would receive Medicaid matching funds for the use of outstationed eligibility workers.

In addition, farmworkers have intermittent income due to the seasonal nature of their work. When this is combined with short enrollment periods and frequent re-verification processes, farmworkers can become ineligible because at a particular time of year, their earnings may be greater. States could use current flexibility to establish longer enrollment time periods (up to 12 months) as well as less restrictive income methodologies for those with intermittent income. Although, in doing so, states should be aware that applicants and recipients who are not migrant farmworkers might also be able to take advantage of these steps. For example, farmers and fisherman with intermittent income could also benefit from a less restrictive income methodology.

NATIONAL MIGRANT FAMILY COVERAGE

Because of the predominately male workforce, many farmworkers are not eligible for Medicaid and SCHIP under current eligibility categories. Proposals to extend coverage on a national basis to migrant farmworkers that involve the establishment of a new Federal program for a newly created eligibility group would be a significant alteration from the way existing Medicaid eligibility determinations are made since there is no precedent for providing Medicaid or SCHIP eligibility based on employment in a particular industry or line of work. Including an additional eligibility criteria or creating a state-Federal partnership with a state buy-in would likely lead to significant additional costs. It is more appropriate to expand eligibility categories on a basis other than type or place of employment.

The Administration has proposed a variety of options to expand coverage for the uninsured currently not covered by Federal or private programs. Moreover, national migrant family

coverage could duplicate existing coverage for those currently eligible for Medicaid and SCHIP, since as previously noted, states have many options under current law to increase enrollment of current eligibles.

PUBLIC-PRIVATE PARTNERSHIPS

Opportunities exist for developing public-private partnerships to develop coverage alternatives for eligible farmworkers and their families.

One such option is the President's proposed Cover the Kids initiative. This FY 2007 budget proposal would provide \$100 million in annual grants for states, community- and faith-based organizations, and other organizations that help to enroll eligible but unenrolled children. One of the primary purposes of the initiative is to identify children that have been hard to enroll. If enacted, this initiative could significantly advance our Nation's ability to identify eligible children of migrant farmworkers, who have been so hard to reach and enroll, and improve their health as a result.

Two additional viable options are premium assistance programs and resource pooling programs.

Premium Assistance Programs Building on the success of premium assistance programs in Medicaid and SCHIP, states could develop premium assistance programs with employers of farmworkers and use a commercial insurance plan to provide the coverage. Medicaid or SCHIP funds could be used to help workers pay the premiums necessary to enroll themselves and their families in employer-sponsored health insurance. There are different types of premium assistance:

- The traditional approach is under section 1906 of the Social Security Act, the Health Insurance Premium Payment (HIPP) program. HIPP allows the state or Medicaid agency to check to see if an applicant has access to employer coverage when they are applying for public coverage. If the applicant has access to employer-sponsored coverage and if the state determines that coverage is cost-effective, the applicant is required to enroll in the employer-sponsored coverage and the state pays the employee share of the premium. The state then provides wrap-around coverage to the Medicaid enrollee for services offered under Medicaid that are not offered in the employer's plan.
- Another approach is under the Health Insurance Flexibility and Accountability (HIFA) initiative, which is a section 1115 demonstration. Under HIFA, states use state, Federal (Medicaid and SCHIP), employer, and employee contributions to expand employment-based coverage for low-income families. CMS has approved premium assistance demonstrations in Idaho, Illinois, Oregon, and New Mexico (not implemented).
- Alternative approaches use public funds, such as Medicaid (using section 1115 demonstration waivers) to encourage expansion of employment-based coverage for low-income workers and their families. A few counties in Michigan have used this approach to provide coverage to low-income workers. In these counties, employers, employees, and the county governments split the premium cost three ways. In general,

premium assistance helps provide coverage of workers, promotes cost savings from the states' perspective by accessing employer contributions, encourages job stability and attachment to the workforce.

- Section 6044 of the Deficit Reduction Act (DRA) of 2005 provides new opportunities for premium assistance programs in Medicaid. For certain categories of individuals who are eligible for Medicaid, the DRA allows States to offer coverage through benchmark packages that are more comparable to those in the private sector. The benchmark package option could be used in states to help provide eligible farmworkers with the ability to access private health insurance through premium assistance for purchasing employer coverage. SCHIP programs have been allowed to provide benchmark coverage since SCHIP's inception.

Resource Pooling A group of states could work with growers and other employers of farmworkers to pool their financial resources to pay for private insurance coverage of employees. Employees could contribute a nominal amount in the form of co-payments. Employers and a consortium of states could agree to what the employer contribution should be. It could be a fixed amount or a fixed percentage of the premium. Then the states could subsidize the remainder of the premium. In order to address portability issues, the employers and states could select a commercial insurance carrier with business in these states to provide the coverage.

SUMMARY

In response to the Congressional mandate, CMS convened an intra-departmental HHS workgroup and convened an expert advisory panel to discuss possible solutions to the challenges of Medicaid and SCHIP access and portability. This expert advisory panel meeting, held on December 2, 2003, was structured to both obtain input from the expert consultants and to encourage a facilitated discussion among the consultants and selected observers.

The report provided a background on the issue of Medicaid and SCHIP eligibility and portability in the context of other factors including the nature of the migrant and seasonal workforce, the predominance of a male workforce, low income and living costs, illness and participation in insurance arrangements, and residence. It also describes issues related to enrollment in Medicaid and SCHIP, including language and culture, outreach and outstationed eligibility assistance, and eligibility determinations and applications, especially pertaining to citizenship and immigration status and income determinations. Issues pertaining to the portability of Medicaid and SCHIP also were described including verification and enrollment challenges involving applications and eligibility determination time periods and residency status determinations as well as payments for out-of-State services.

The legislation asked the Department to consider six possible areas of solutions: interstate compacts, demonstration projects, use of current law flexibility, national migrant family coverage, public-private partnerships, and other possible solutions. The report includes information in five of these areas because no other possible solutions were identified. This report offers many potential areas for further program policy development that could lead to improving migrant farmworker Medicaid and SCHIP eligibility which States may wish to

explore in the future. It also includes options to facilitate portability within and across States. The Department will work with states and other stakeholders to facilitate the development of possible solutions as they are proposed by States. The report's five possible solution areas include:

1.) Interstate Compacts

By establishing and joining an interstate compact on medical assistance to migrant farmworkers and their families, states can more readily recognize each other's eligibility determinations and reimburse out-of-state providers; as a result, they can provide more seamless Medicaid coverage to migrant farmworkers and their families. This model has been used previously; States currently participate in a variety of interstate compacts including one pertaining to Federal adoption assistance/Medicaid recipients. CMS is available to work with states who wish to implement an interstate compact to enhance portability of Medicaid coverage for eligible migrant farmworkers and their families. Advantages of interstate compacts could include:

- Faster verification and enrollment when moving from state to state for work.
- Out of area coverage across states after "home state" enrollment.

2.) Demonstration Projects

States may wish to use current law demonstration authority to test innovative methods of increasing the ability of eligible farmworkers and their families to enroll in the Medicaid and SCHIP programs. Such innovative methods could include expanded interstate compacts and Medicaid and SCHIP vouchers.

3.) State Activities under Current Law Flexibility

Existing authority enables states to conduct a wide range of activities for eligible and participating Medicaid recipients. Some of these may be designed to:

- Improve service delivery coordination;
- Enhance enrollment and portability arrangements;
- Improve coordination between HRSA-sponsored community and migrant health centers and state Medicaid and SCHIP programs; or
- Enhance Medicaid and SCHIP managed care coordination, at state and health plan levels, to facilitate Medicaid enrollment and portability.

Under SCHIP, states have the option of using the unborn child state plan amendment. CMS allows States to cover pregnancy-related services and care for unborn children through SCHIP and, as of June 2006, nine States (Arkansas, California, Illinois, Massachusetts, Michigan, Minnesota, Rhode Island, Texas, and Washington) have adopted this option. This option could make a significant difference in the health of infants in states with large numbers of pregnant migrant workers.

States could coordinate outreach and enrollment activities for eligible farmworkers and their families with community and migrant health centers funded under section 330 of the Public Health Service Act and through the use of outstationed eligibility workers at such centers under the authority of section 1902(a)(55) of the SSA. States would receive Medicaid matching funds for this expanded use of outstationed eligibility workers.

4.) National Migrant Family Coverage

Proposals to extend coverage on a national basis to migrant farmworkers that involve the establishment of a new Federal program for a newly created eligibility group would be a significant alteration from the way existing Medicaid eligibility determinations are made since there is no precedent for providing Medicaid or SCHIP eligibility based on employment in a particular industry or line of work.

The Administration has proposed a variety of options to expand coverage for the uninsured currently not covered by Federal or private programs, and national migrant family coverage could duplicate existing coverage for those currently eligible for Medicaid and SCHIP.

5.) Public-Private Partnerships

Opportunities exist for developing public-private partnerships to develop coverage alternatives for eligible farmworkers and their families. One such option is the President's proposed Cover the Kids Initiative. Two additional viable options are premium assistance programs and resource pooling programs.

S.1533/P.L.107-251

Health Care Safety Net Amendments of 2002 (Enrolled as Agreed to or Passed by Both House and Senate)

SEC. 404. STUDY REGARDING BARRIERS TO PARTICIPATION OF FARMWORKERS IN HEALTH PROGRAMS.

(a) **IN GENERAL-** The Secretary shall conduct a study of the problems experienced by farmworkers (including their families) under Medicaid and SCHIP. Specifically, the Secretary shall examine the following:

- (1) **BARRIERS TO ENROLLMENT-** Barriers to their enrollment, including a lack of outreach and outstationed eligibility workers, complicated applications and eligibility determination procedures, and linguistic and cultural barriers.
- (2) **LACK OF PORTABILITY-** The lack of portability of Medicaid and SCHIP coverage for farmworkers who are determined eligible in one State but who move to other States on a seasonal or other periodic basis.
- (3) **POSSIBLE SOLUTIONS-** The development of possible solutions to increase enrollment and access to benefits for farmworkers, because, in part, of the problems identified in paragraphs (1) and (2), and the associated costs of each of the possible solutions described in subsection (b).

(b) **POSSIBLE SOLUTIONS-** Possible solutions to be examined shall include each of the following:

- (1) **INTERSTATE COMPACTS-** The use of interstate compacts among States that establish portability and reciprocity for eligibility for farmworkers under the Medicaid and SCHIP and potential financial incentives for States to enter into such compacts.
- (2) **DEMONSTRATION PROJECTS-** The use of multi-state demonstration waiver projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to develop comprehensive migrant coverage demonstration projects.
- (3) **USE OF CURRENT LAW FLEXIBILITY-** Use of current law Medicaid and SCHIP State plan provisions relating to coverage of residents and out-of-State coverage.
- (4) **NATIONAL MIGRANT FAMILY COVERAGE-** The development of programs of national migrant family coverage in which States could participate.
- (5) **PUBLIC-PRIVATE PARTNERSHIPS-** The provision of incentives for development of public-private partnerships to develop private coverage alternatives for farmworkers.
- (6) **OTHER POSSIBLE SOLUTIONS-** Such other solutions as the Secretary deems appropriate.

(c) **CONSULTATIONS-** In conducting the study, the Secretary shall consult with the following:

- (1) Farmworkers affected by the lack of portability of coverage under the Medicaid program or the State children's health insurance program (under titles XIX and XXI of the Social Security Act).
- (2) Individuals with expertise in providing health care to farmworkers, including designees of national and local organizations representing migrant health centers and other providers.
- (3) Resources with expertise in health care financing.
- (4) Representatives of foundations and other nonprofit entities that have conducted or supported research on farmworker health care financial issues.
- (5) Representatives of Federal agencies which are involved in the provision or financing of health care to farmworkers, including the Health Care Financing Administration and the Health Research and Services Administration.
- (6) Representatives of State governments.
- (7) Representatives from the farm and agricultural industries.
- (8) Designees of labor organizations representing farmworkers.

(d) DEFINITIONS- For purposes of this section:

- (1) FARMWORKER- The term `farmworker' means a migratory agricultural worker or seasonal agricultural worker, as such terms are defined in section 330(g)(3) of the Public Health Service Act (42 U.S.C. 254c(g)(3)), and includes a family member of such a worker.
- (2) MEDICAID- The term `Medicaid' means the program under title XIX of the Social Security Act.
- (3) SCHIP- The term `SCHIP' means the State children's health insurance program under title XXI of the Social Security Act.

(e) REPORT- Not later than 1 year after the date of the enactment of this Act, the Secretary shall transmit a report to the President and the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Secretary considers appropriate.

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¹⁶ NIOSH/NORA: *Hired Farmworkers: Factors in Determining the Occupational Health Status of Hired Farm Workers* <<http://www.cdc.gov/niosh/hfw-factors.html>>.

¹⁷ NIOSH/NORA: *Hired Farmworkers: Factors in Determining the Occupational Health Status of Hired Farm Workers* <<http://www.cdc.gov/niosh/hfw-factors.html>>.

¹⁸ Section 1115 of the SSA provides the Secretary of HHS with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary, (are) likely to assist in promoting the objectives within the Medicaid statute. States can request section 1115 authority to create a standard set of benefits across states or to expand coverage to groups of individuals, including parents and caretakers. Budget neutrality is required under section 1115 authority and implemented per the budget policies of the Office of Management and Budget. In the case of SCHIP demonstrations, including HIFA demonstrations, proposals must demonstrate allotment neutrality. States are encouraged to apply for demonstration authority under Section 1115 when no other means may accomplish the goal under current Medicaid and SCHIP program authorities. Demonstration projects can be designed to address portability issues through facilitating interstate compact efforts.